GENERAL INFORMATION – FORM WC-701

The form WC-701 (Form 701) is used to report to the Agency payment of weekly compensation benefits made to the employee. Attorney fees, rehabilitation costs, medical expenses, etc. should not be reported on the form. Burial expenses must be reported by the employer on form WC-106 or a receipt of payment will be requested.

The filing number should always be #1 the first time the Form 701 is submitted for a claim, and then increase sequentially for subsequent filings.

It is critical that all subsequent filings contain the **exact** SSN and DOI that were reported on the first filing. If this information was previously reported in error, the correction(s) should be clearly marked on the form.

Friend of the Court payments should not be reported to the Agency.

All Agency orders have a nine digit number written in the upper right hand corner consisting of the mailed date and a three digit sequential number. All Forms 701 that are filed pursuant to an award (basis of payment anything other than "A") should have the order number included in the space provided below section D.

Redemption amounts should not be reported on a Form 701. If the redemption involves a claim which is in payment status, the system will automatically close out the weekly payments assuming that the weekly rate, date of injury and carrier listed on the redemption order match the information on the latest Form 701. If not, a Form 701 must be filed closing out the weekly payments. A Form 701 must also be filed if partial benefits are being paid at the time of the redemption.

Lump sum advance payment amounts should not be reported on a Form 701. If the advance payment order results in a reduction or termination of the weekly rate, a Form 701 must be filed showing the rate change or termination.

In February of each year, the Agency runs a program which closes all open paying claims as of December 31 and reopens them on January 1. Once that is done, an Open Claim Validation Report is sent to each carrier or service company listing all claims that closed and reopened as well as those that could not be closed because of an error. This report should be used to verify that all claims on the report are still in open payment status and that the rate is correct. If not, the appropriate Forms 701 should be filed. If partial benefits are being paid, the employee worked less than a 5 day work week, or the compensation rate is in error, a Form 701 must be filed.

Forms 701 which are filed to report payment of accrued benefits as a result of an order or agreement which cover multiple benefit periods should have the Report of Accrued Benefits worksheet (or a similar format) attached and include all available information: basis, benefit type, special payment, weekly rate, from and through dates and total amounts paid for each payment period. Interest payments, when applicable, should be reported on a separate line from the accrued benefit period(s) and include the special payment code, through date and total interest payment only.

FILING INSTRUCTIONS FOR FORM 701

PART A

This section must be completed when filing the Form 701. Extreme care should be taken to ensure that all subsequent filings contain the same correct SSN and DOI.

- #1 Social Security Number: 9 digit numeric.
- #2 Date of Injury: Must be complete date (mm/dd/yyyy).
- #3 Employee Name: Employee's last name, first name and middle initial.
- #4 Date of Birth: Must be complete date (mm/dd/yyyy).
- #5 Date of Death: If employee is deceased, enter complete date (mm/dd/yyyy).
- #6-9 Employee Address: Complete mailing address of employee.
- #10 Employer Name: Enter complete business name of employer, d.b.a., etc.
- #11 Federal ID Number: Enter 9 digit Federal ID number used by the employer listed in #10.
- #12 Injury Location Code: This should be left blank. It is an internal three digit location code that is assigned and used by Agency staff only.
- #13-16 Employer Address: Complete address of employer, including number, street, city, state and ZIP Code.
- #17 Carrier or Self-Insured Name: Enter complete name of carrier or self-insured employer.

 A service company name should not be reported in this field.
- #18 NAIC or Self-Insured Number: Carriers should report their 5 digit NAIC number and 4 digit group code, and self-insureds should report their 8 digit self-insured ID number.
- #19 Self-Insurer's Service Company Name: Enter the name of the service company handling the claim. Enter the service company name **only** if the employer is an Agency authorized self-insurer. This line is to be left blank if a carrier has written a standard market policy or a large deductible policy.
- #20 Service Company ID Number: The 3 digit service company ID number assigned by the Agency must be reported if a service company name is listed in #19.
- #21 ZIP Code of Issuing Office: ZIP Code of carrier or self-insurer (or service company filing form on behalf of an Agency authorized self-insurer) filing the form. The ZIP Code will be used in conjunction with the carrier or self-insurer service company to identify the mailing address of the appropriate office where correspondence should be sent.
- #22 Carrier or Self-Insured Claim Number: Submitter's claim or file number, if applicable. This number will appear on all system generated correspondence.

- #23 Date Carrier Received Notice of Injury: This information is required on all voluntary payment claims to determine promptness of payment.
- #24 Date First Payment Made: The date the first check was sent out on this claim. This date is required on all voluntary payment claims to determine promptness of payment. If the employer is continuing to pay wages while the compensability issue is being resolved or benefits are being coordinated under a wage continuation plan, the date first payment made should be the same as the from date in Part D.

PART B

This section must be completed when filing the Form 701.

- #25 Nature of Injury: Provide a brief description of the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.
- #26 Part of Body: Provide a brief description of the part of body affected by the injury or disease. If desired, the codes from the list of filing codes may be entered in addition to the description.
- #27 Average Weekly Wage: Total weekly wages from place of injury, excluding fringes.
- #28 Discontinued Fringes: Weekly fringe benefits that are not continuing during the disability period.
- #29 Second Employer AWW: Total wages from second employer, if applicable.
- #30 Second Employer Discontinued Fringes: Discontinued fringes from second employer, if applicable.
- #31 Tax Filing Status on Date of Injury: Employee's tax filing status at the time of injury using the federal income tax eligibility criteria. The status does not change during the life of the claim.
- #32 Last Day Worked: Last day preceding the current disability period for which the employee received full wages.
- With the employee works less than a 5 day week, we are unable to work per week. If the employee works less than a 5 day week, we are unable to calculate the total amount paid. Therefore, if any of these claims are in open payment status at the end of the year, a Form 701 must be filed reporting the amount of compensation paid during the year. All payments made for dates of injury on and after May 11, 1999 must be calculated on a 7 day work week per Rule 408.31a.
- #34 Number of Dependents: Number of dependents, not including the employee.

PART C

This section must be completed when filing the Form 701. The information should always pertain to the latest payment period reported on the form.

- #35 Reason for Filing: The appropriate code must be entered on all filings:
 - A Commencing Benefits: Used whenever benefits are commencing and continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.
 - B Change in Weekly Rate: Used whenever there is a change in the current rate and benefits are continuing. In Part D, complete the entire first line (except for the termination reason) in order to close out the old rate, as well as the first half of the second line in order to report the new total weekly rate and from date. If benefits covered more than one calendar year, the from date on the first line should always be January 1 of the current year. When benefits are changing from partial to total, a wage statement showing the calculation of partial payments must also be attached to the Form 701.
 - C Terminating Benefits: Used whenever benefits that were previously reported are now being terminated. In Part D, complete the entire first line showing the total payments made for the current calendar year only.
 - D Commencing and Terminating Benefits: Used whenever benefits that have never been previously reported are both commencing and terminating. In Part D, complete the entire first line showing the total payments that were made.
 - E Reimbursement by a Fund: Used whenever the rate is staying the same but reimbursements are now being received from either the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. In Part D, complete the entire first line to close out the rate and payment period (if payments covered multiple calendar years, use January 1 of the current calendar year) for which the carrier is responsible, as well as the first half of the second line in order to give us the new from date for which reimbursement takes effect.
 - F Reopening Claim: Used whenever a claim that had previously been in payment status is now reopening and benefits are continuing. In Part D, complete the basis of payment, benefit type, special payment (if applicable), weekly rate, and from date.
 - G Reopening and Closing Claim: Used whenever benefits are both commencing and terminating on a claim that had previously been in payment status. In Part D, complete the entire first line showing the total payments that were made.
 - H Yearly Report of Partial Payments: Used to report the amount of partial benefits that were paid on all claims which are in partial benefit status as of December 31. A wage statement should also be attached. This code should also be used when reporting yearly payments on any claim still in payment status at the end of the year in which the employee worked less than a 5 day work week. In Part D, complete the entire first line (except for the termination reason) in order to report the partial payments that were made during the previous calendar year (show the through date as close to

December 31 as possible) as well as the first half of the second line using a from date one day after the through date. A partial payment worksheet must also be attached to the form.

- I Error on Previous Filing: Used whenever information was improperly reported on a previous Form 701.
- #36 Weekly Compensation Base Rate: The base rate which is owed prior to taking into account any adjustment(s) specified in line 37.
- #37 Weekly Adjustments to Base Rate: This line should always be completed when the base rate in line 36 does not match the "total weekly rate" in Part D. Record the appropriate code(s) and weekly dollar amount(s). If the code is "A" thru "G" (coordination of benefits), the appropriate section in Part E should also be completed on the back of the form. If the code is "J" or "K," the order number must also be entered in the space provided below Part D. If the code is "R," rate reduction due to post injury wage earning capacity (PIWEC), Part F should also be completed on the back of the form.
- Weekly Amount Being Reimbursed by a Fund: Indicate the appropriate code(s) and weekly dollar amount(s) being reimbursed by the Silicosis, Dust Disease and Logging Industry Compensation Fund or the Vocationally Handicapped Provisions of the Second Injury Fund. Do not record any Compensation Supplement Fund payments (adjustment code of "I") or Second Injury differential benefits (adjustment code of "L"). These amounts should be reported in #37. Also, do not report any reimbursements received as a result of the 70% or Dual Employment provisions. This information will be provided to us by the Second Injury Fund.

PART D

This section must be completed as follows when filing the Form 701 on a claim.

BASIS OF PAYMENT:

Indicate the appropriate code from the list of WC-701 Filing Codes. When a claim is being paid pursuant to any type of order, including a voluntary payment form (WC-115), include the order number in the space provided below Part D.

BENEFIT TYPE:

Indicate the appropriate code from the list of WC-701 Filing Codes. This information is always necessary unless a Special Payment type code is present. Also, the first filing reporting a specific loss benefit type "C" should include a copy of the amputation chart signed by the physician or affidavit of vision loss, whichever applies. The number of loss weeks and effective date of loss should be completed below Part D.

When the benefit type is "D" (permanent total), there must be an adjustment code of "L" (SIF differential benefits) and an amount reported in #37.

When the benefit type is "W" (rate with post injury wage earning capacity), there must be an adjustment code of "R" and an amount reported in #37.

SPECIAL PAYMENT:

This code is only necessary when the payment period is pursuant to an award. When interest is being reported, the through date should reflect the date that the accrued benefits were paid.

TOTAL WEEKLY RATE:

This should reflect the amount the employee actually receives per week and should equal the base rate in line 36 plus or minus any adjustments reported in line 37.

The weekly rate should be left blank when the benefit type is "B" (partial wage loss).

FROM DATE:

The effective date for the payment period. Do not include the waiting week for the initial disability period unless benefits were paid for those dates. If benefits covered more than one calendar year, the from date should be January 1 of the current year. This field may be left blank when special payment code is "B" (interest).

THROUGH DATE:

The ending date (current calendar year only) of the rate/benefit type or the payment termination date, whichever applies. If a special payment code of "B" (interest) is being reported, the through date should reflect the date accrued benefits were paid.

TOTAL AMOUNT PAID:

Indicate the total amount paid to the employee for the payment period. This field is required whenever a through date is present. If an overpayment was made but not recouped, the amount actually paid to the employee should be reflected. If partial benefits are being terminated, the total amount paid must be entered in Part D.

YEAR PAID:

Indicate the year the total amount was paid for the payment period reported on the form.

TERMINATION REASON:

When the reason for filing is "C," "D," or "G," (all terminating benefits), the termination reason code is required. Whenever partial benefits are being terminated, a partial payment worksheet must be attached. If the termination reason is "E" (claimant deceased), a death certificate must be attached.

BELOW PART D

ORDER #:

If payments are being made pursuant to an award or voluntary payment form (WC-115), provide the 9 digit order number that is located in the upper right hand corner of all orders mailed out by the Agency.

SPECIFIC LOSS:

If the benefit type code is "C" (specific loss), enter the exact number of specific loss weeks as well as the effective date of the loss. An amputation chart (WC-728) or vision affidavit, whichever is applicable, should also be attached.

OTHER FILING CODES:

If any of the codes used on the form refer to "Other," the exact reason must be listed here.

- #39 Authorized Signature: The signature of an individual authorized to file this form.
- #40 Person Handling Claim: Print the name of the individual who is handling the claim.
- Telephone Number: Enter the telephone number, including extension, of the individual listed in #40 who is handling the claim.
- #42 Date: Enter the date the form was prepared.

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING	#		

PART A				•					
Social Security Number	2. Da	ite of Injury	3. Employee Name (Last, First, MI)		4. Date	e of Birth	5. Date of Death		
6. Employee Street Address	<u> </u>			7. City	8. Stat	te	9. ZIP C	9. ZIP Code	
10. Employer Name					11. Fe	ederal ID Number	12. Injur	y Location Code	
								N/A	
13. Employer Street Address				14. City	15. Sta	ate	16. ZIP (Code	
17. Carrier or Self-Insured Na	ame				18. NA	AIC or Self-Insured	d Number		
19. Self-Insurer's Service Co	mpany Name				20. Se	ervice Company ID	Number		
21. ZIP Code of Issuing Offic	e 22. C	arrier or Self-Insure	ed Claim Number	23. Date Carrier Received Not	ice of Injury	24. Dat	e First Payment	Made	
PART B	ļ								
25. Nature of Injury				26. Part of Body					
27. Average Weekly Wage		28. Discontinu	ued Fringes	29. Second Employer A.W.V	V.	30. Second Em	ployer Discontin	ued Fringes	
\$		\$		\$		\$			
31. Tax Filing Status on Date	of Injury	32. Last Day	Worked	33. Number of Days in Work	Week	34. Number of Dependents			
PART C						l			
35. Reason for Filing				36. Weekly Compensation E	Base Rate				
				\$					
37. Weekly Adjustments to B				- 1					
\$		\$_		\$		\$	S		
\$		\$_		\$			S		
38. Weekly Amount Being Re	· ·								
\$		\$_		\$		\$	S		
PART D									
BASIS OF BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	Н	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
IF BASIS OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYME	NT) OR LINE 37 IS EQUA	L TO "J" OR	R "K," ENTER	ORDER#	<u> </u>	
		-		EEKS AND EF					
IF ANY FILING CODES									
Mak	ing a false			e purpose of obtaining of ion, or both, and denial			n result in		
	THIS IS TO	CERTIFY THA	T A COPY OF THIS F	FORM HAS BEEN MAILED	OR GIVEN T	O THE EMPLO	DYEE		
39. Authorized signature			40. Person Handling Clair	m (Please print)	41. Telepho	one Number	42. I	Date	
	TO EMPLOYE	- 15 4407 05 71	IE A DOL /E IN IEO DA A TIO		01 IT 1 0T TI IE				

PART F - COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER			
A. WEEKLY BENEFIT AMOUNT								
B. 80% AFTER-TAX AMOUNT OF (A)								
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25			
C. 100% AFTER-TAX AMOUNT								
D. FICA TAX ¹								
E. STATE INCOME TAX ¹								
F. % EMPLOYER CONTRIBUTION								
G. INCOME TO BE COORDINATED ²								
¹ Does not apply in all cases. If applicable, includithe year of injury. ² Line G = (Line C + D + E) x Line F. (This figure	should appear in Part C	, Line 37, with the appropriate adj	ustment code)					
A. MONTHLY SOCIAL SECURITY OLD AGE F			only. (Enter net benef	it with code "B" in Part C, Lind	e 37)			
B. WEEKLY SOCIAL SECURITY OLD AGE RE	ETIKEMENT AMOUNT (Line A divided by 4.33)						
C. 50% OF LINE B								
D. 50% OF BASE RATE (Found in Box 36)					•			
E. IS DATE OF INJURY ON OR AFTER 12/19/				☐ YES ☐] NO			
IF NO – COORDINATE AMOUNT IN LINE O	<u> </u>							
IF YES – WERE SOCIAL SECURITY OLD A	AGE RETIREMENT BEN	IEFITS BEING PAID ON THE DA	TE OF INJURY?	☐ YES ☐] NO			
IF NO – COORDINATE AMOUNT IN LI	INE C							
IF YES – COORDINATE THE LOWES	T AMOUNT FOUND IN I	LINE C OR D						
UNEMPLOYMENT COMPENSAT	ION							
A. NUMBER OF WEEKS AWARDED								
B. BEGINNING DATE OF UNEMPLOYMENT (COMPENSATION							
C. SCHEDULED EXPIRATION DATE								
D. TOTAL WEEKLY UNEMPLOYMENT COMP	PENSATION BENEFITS	(Enter with code "D" in Part C, Lir	ne 37)					
PART F - RATE ADJUSTM (MCL 418.301(8) & 401(6))		OST INJURY WAGE	E EARNING C	APACITY (PIWE	EC)			
A. AVERAGE WEEKLY WAGE (On front, Line	27)							
B. 80% AFTER-TAX AMOUNT OF LINE A (See	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)							
C. 100% AFTER-TAX AMOUNT (Line B multiple	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)							
D. GROSS WEEKLY POST INJURY WAGE EA	ARNING CAPACITY (PI	VEC) AMOUNT						
E. DIFFERENCE BETWEEN 100% AFTER-TA If the calculation in line E is less than or equ								
F. 80% of Line E (Line E multiplied by .8) ³								
1: 0070 of Emilo E (Emilo E manapiloa by .o)								
AMOUNT OF ADJUSTMENT FOR PIWEC (This figure should appear on front, Part C, Li If the adjustment calculation shows an amount	ine 37, with appropriate	adjustment code R.	pplied.					

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

WC-701 FILING CODES

LINE 31 - TAX FILING STATUS

- A. Single
- B. Single/Head of Household
- C. Married/Filing Joint
- D. Married/Filing Separate

LINE 35 - REASON FOR FILING

- A. Commencing Benefits F. Reopening Claim
- B. Change in Weekly Rate
 C. Terminating Benefits
 G. Reopening and Closing Claim
 H. Yearly Report of Partial Payments
- D. Commencing and Terminating Benefits I. Error on Previous Filing
- E. Reimbursement by a Fund

LINE 37 - WEEKLY ADJUSTMENTS TO BASE RATE

- A. Wage Continuation Offset (-)
 B. Social Security Coordination (-)
 C. Pension Offset (-)
 D. Unemployment Offset (-)
 E. Disability Insurance Offset (-)

 J. Advance Payment (-)
 K. 30% Appeal Adjustment (-)
 L. SIF Differential Benefits (+)
 M. Double Compensation (+)
 N. Third Party Offset (-)
- F. Self Insurance Offset (-)
 G. Other Benefit Coordination (-)
 O. 2 Years Continuous Disability (+)
 P. Recoupment of Overpayment (-)
- H. Age 65 Reduction (-) Q. Other
- I. Compensation Supplement (+) R. Post Injury Wage Earning Capacity (PIWEC) (-)

LINE 38 - REIMBURSEMENT BY A FUND*

- A. Silicosis, Dust Disease & Logging Industry Compensation Fund
- B. Self-Insurers' Security Fund
- C. SIF/Vocationally Handicapped Provisions
- D. Other

*Do not report reimbursements received as a result of the 70% or dual employment provisions. This information will be provided to the agency by the Second Injury Fund.

PART D - BASIS OF PAYMENT

- A. Voluntary Payment D. Stipulated Award B. Open Award E. Compromise
- C. Closed Award F. Form 115 Voluntary Pay

PART D – BENEFIT TYPE

- A. General Disability E. Death B. Partial Wage Loss F. Other
- C. Specific Loss W. Rate with Post Injury Wage Earning Capacity (PIWEC)
- D. Permanent Total

PART D - SPECIAL PAYMENT

- A. Accrued Benefits C. 30% Appeal Adjustment
- B. Interest D. Other

PART D - TERMINATION REASON

- A. Returned to Work With No Wage Loss E. Claimant Deceased (attach death certificate)
- B. Recovered from Disability F. Closing Out Weekly Due to Redemption
- C. Award Reversed G. Closing Out Weekly Due to Advance Payment
 - End of Specific Loss H. Other

REPORT OF ACCRUED BENEFITS

SS#	DOI	Employee Name	
Order #	Basis Payment Code	Year Paid	

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
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						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$

Basis of Payment Benefit Type Special Payment

A = Voluntary Payment A = General Disability A = Accrued Benefits
B = Open Award B = Partial Wage Loss B = Interest

C = Closed Award C = Specific Loss C = 30% Appeal Adjustment

D = Stipulated Award D = Permanent Total D = Other

W= Rate with Post Injury Wage Earning Capacity (PIWEC)

Weekly Adjustments to Base Rate

Wage Continuation Offset Advance Payment J = Social Security Coordination 30% Appeal Adjustment B = K = C = Pension Offset L = SIF Differential Benefits D = Unemployment Offset M= **Double Compensation** E = Disability Insurance Offset N = Third-Party Offset

H = Age 65 Reduction Q = Other

I = Compensation Supplement R = Post Injury Wage Earning Capacity (PIWEC)

NATURE OF INJURY CODES

Code	Description	Code	Description
300	Abrasions	200	Electric shock, electrocution
183	Abscess	274	Emphysema
281	Aluminagia aluminum avnagura	240	Environmental heat (does not include
201	Aluminosis - aluminum exposure	240	sunburn)
100	Amputation or enucleation (loss of an eye)	260	Epicondylitis
272	Anemia	995	Epilepsy
282	Anthracosis - coal dust	184	Erythema, toxic
152	Anthrax	530	Eye diseases
	Anxiety	210	Fracture
283	Asbestosis - asbestos fibers	220	Freezing (includes frostbite)
	Asphyxia	260	Ganglion cyst
	Asthma	276	Gastro-enteritis
	Asthma, toxic (systemic poisoning)	276	Gastro-intestinal diseases
552	Benign and unspecified tumor	273	Hay fever, toxic (systemic poisoning)
590	Bites, human and non-toxic animal	230	Hearing loss or impairment
300	Blisters	991	Heart attack
272	Blood diseases (includes purpura)	991	Heart conditions
183	Boils	240	Heatstroke
572	Bronchitis	320	Hemorrhoids (circulatory system)
274	Bronchitis, toxic (systemic poisoning)	330	Hepatitis (serum & infective)
153	Brucellosis	250	Hernia, rupture
160	Bruise	190	Herniated disc
130	Burn (chemical)	159	Herpes
120	Burn or scald (heat)	991	Hypertension
260	Bursitis	150	Infective or parasitic disease, unspecified
284	Byssinosis - cotton dust	572	Influenza
551	Cancer	274	Influenza, toxic (systemic poisoning)
183	Carbuncles	294	Ionizing radiation - Isotopes
562	Carpal tunnel	293	Ionizing radiation - X-Ray
310	Cartilage, torn	530	Iritis
183	Cellulitis	260	Joints, inflammation or irritation
561	Central nervous system	170	Laceration
561	Cerebral palsy	551	Leukemia
510	Cerebrovascular & other circulatory conditions	184	Lichen
159	Chicken pox	530	Loss of vision
276	Colitis	551	Malignant tumor
520	Complications peculiar to medical care (toxic or non-toxic)	159	Measles
140	Concussion (brain, cerebral)	540	Mental disorders
154	Conjunctivitis (non-toxic)	292	Microwave, radiation effects
530	Conjunctivitis, chemical	561	Migraine
160	Contusion	995	Miscarriage
160	Crush	400	Multiple injuries
170	Cut	159	Mumps
	Damage to prosthetic devices (includes	000	
950	eyeglasses, false teeth, etc.)	260	Muscles, inflammation or irritation Nerves and peripheral ganglia (includes
540	Depression	562	Bell's Palsy)
		11	

NATURE OF INJURY CODES

Code	Description	Code	Description
540	Derangement, internal	560	Nervous system, conditions of, unspecified
185	Dermatitis, allergenic or contact	540	Neurosis
180	Dermatitis, unspecified	900	No injury or illness
190	Dislocation & dislocated disc	999	Nonclassifiable
110	Drowning	990	Occupational disease (not elsewhere classified)
151	Dysentery, amebiasis	159	Other infective diseases
500	Effects of changes in atmospheric pressure (equilibrium)	995	Other injury, not elsewhere classified
287	Other pneumoconiosis and related diseases	273	Sinusitis, toxic (systemic poisoning)
184	Other skin conditions	189	Skin conditions, unspecified
279	Other toxic effects on one system only	170	Sliver
190	Pinched nerve (back only)	273	Smoke inhalation
310	Pinched nerve (other than back)	310	Sprains
280	Pneumoconiosis & related diseases, unspecified	310	Strains
289	Pneumoconiosis with tuberculosis	110	Strangulation
572	Pneumonia	540	Stress
274	Pneumonia, toxic (systemic poisoning)	510	Stroke
274	Pneumonitis	110	Suffocation
280	Pneumothorax	291	Sunburn, etc. (non-ionizing radiation)
270	Poisoning, systemic, unspecified	240	Sunstroke
271	Poisoning, toxic material	580	Symptoms & ill-defined conditions (e.g., fainting)
183	Primary Infections of the skin	260	Tendinitis
184	Pruritus	260	Tendons, inflammation or irritation
170	Puncture	260	Tenosynovitis, stenosing
290	Radiation effects, unspecified	156	Tetanus
570	Respiratory System, conditions of, unspecified	275	Toxic hepatitis
581	Rhinitis	157	Tuberculosis
273	Rhinitis, toxic (systemic poisoning)	550	Tumor, neoplasm, unspecified
310	Rotator cuff tear	571	Upper respiratory
300	Scratches	510	Varicose veins
285	Siderosis - metallic dust	295	Welder's flash (eyes only)
286	Silicosis - silica dust	310	Whiplash
	en two codes are listed, the first represents nature		
VVIIE	in two codes are listed, the hist represents hattite	o oi iiiju	ny and the second is part of body

PART OF BODY CODES

Code	Description	Code	Description
410	Abdomen (include internal organs); Hernia,	350	Fingertip(s)
410	inguinal	330	i ingerup(s)
520	Ankle	530	Foot (not ankle or toe); Metatarsal
310	Arm(s), above wrist, unspecified	315	Forearm; Radius; Ulna
318	Arm, multiple	397	Hand & Finger(s)
319	Arm, not elsewhere classified	330	Hand (not wrist or fingers); Metacarpal
801	Arteries; Blood; Circulatory system; Heart; Veins	198	Head, multiple
420	Back (include back muscles); Coccyx; Lumbar; Sacrum; Spinal cord; Spine	100	Head, unspecified
311	Biceps; Humerus; Triceps; Upper arm	513	Knee; Patella
820	Bladder; Excretory system; Intestines; Kidneys	510	Leg(s) (above ankle), unspecified
800	Body system, unspecified	518	Leg, multiple
830	Bones; Joints; Muscles; Musculo-skeletal system; Tendons	519	Leg, not elsewhere classified
110	Brain; Concussion	144	Lips; Mouth (includes sense of taste, excludes teeth); Throat; Tongue
430	Breastbone; Chest (internal organs); Pectorals; Ribs; Sternum; Thorax	598	Lower extremities, multiple
440	Buttocks; Hips; Pelvic organs; Pelvis	500	Lower extremities, unspecified
200	Cervical; Neck	850	Lungs; Respiratory system
141	Cheek; Chin; Jaw; Mandible	700	Multiple parts (use when more than one major body part has been affected)
450	Clavicle; Deltoid; Scapula; Shoulder(s)	146	Nasal passages; Nose (includes sense of smell); Sinus
810	Digestive system	999	Nonclassifiable (insufficient information to identify affected part)
121	Ear(s), external	880	Other body systems
124	Ear(s), internal	150	Scalp
120	Ear(s), unspecified	160	Skull
313	Elbow; Olecranon	147	Teeth
840	Epilepsy; Nervous system	540	Toe(s)
130	Eye(s); Eyelid; Optic nerves; Vision	550	Toetip(s)
148	Face, multiple parts	498	Trunk, multiple
149	Face, not elsewhere classified; Forehead	400	Trunk, unspecified
140	Face, unspecified	398	Upper extremities, multiple
511	Femur; Thigh	300	Upper extremities, unspecified
515	Fibula; Lower leg; Tibia	320	Wrist
340	Finger(s)		

List of Form WC-701 Examples

EXAMPLE#	FILING REASON	DESCRIPTION
1	А	Commencing benefits (no adjustments to base rate)
2	А	Commencing benefits (with adjustments to base rate)
3	В	Change in weekly rate due to decrease in dependents
4	С	Terminating benefits
5	D	Commencing and terminating benefits
6	F	Reopening claim
7	G	Reopening and closing claim
8	Н	Yearly report of partial payments
9	В	Commencing benefits as the result of an open award
10	E	Reporting a compromised payment
11	D	Change in weekly rate due to reporting of P&T differential benefits
12	А	Rate with post injury wage earning capacity (PIWEC)
13	А	Old-age social security benefits being paid on DOI occurring after 12/19/11
14	А	Old-age social security benefits not being paid on DOI occurring after 12/19/11
15	А	Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

EXAMPLE #1 - Filing Reason "A" Commencing benefits (no adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1
----------	---

02/12/2007

517-999-9999

				P.O. Box 3001	6, Lansing	, MI 48909						
1. Social Sec 1111-22-3	curity Number		ate of Injury	3. Employee Name (Last, First, MI) Doe, John R.				te of Birth 04/1950		5. Date o	of Death	
	Street Address th Elm Stre	et			7. City Lansing		8. Sta	te		9. ZIP Co		
10. Employe	r Name Auto Repai	ir						ederal ID Num	nber		Location Code	
	r Street Address outh Baker				14. City Lansing		15. St	ate		16. ZIP 0	Code	
	r Self-Insured Na States Insur		npany					AIC or Self-In	sured Nu	umber		
19. Self-Insu	rer's Service Cor	mpany Name					20. Se	ervice Compa	ny ID Nu	ımber		
21. ZIP Code 48912	21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1					ier Received Notio	ce of Injury		. Date Fi 2/07/2	irst Payment 2007	Made	
PART B 25. Nature of	f Injury				26. Part of I	Body						
Sprain (Ankle (,						
-	Weekly Wage		28. Discontinu	•		Employer A.W.W	•		d Employ	oyer Discontinued Fringes		
\$ 450	.00 g Status on Date	of Iniury	\$ 0.00 32. Last Day \		\$ 33. Number					umber of Dependents		
C 02/01/2007					7 3							
PART C												
35. Reason f	or Filing					Compensation Ba	ise Rate					
A Weekly A	Adjustments to Ba	asa Rata			\$ 31	0.14						
37. Weekly F	-		\$			\$			\$			
	\$		\$_			\$			\$			
38. Weekly A			Fund (Not reported	on Line 37)								
	\$		\$_			\$		<u> </u>	_ \$_			
PART D												
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT P	AID Y	ÆAR PAID	TERMINATION REASON	
Α	Α		\$ 310.14	02/02/2007	,							
5 DAGIO 6	NE DANGAE: ::		T. I.A.A.I. "A.N. ". "	NI INTA DV DAVA :=:	IT/ 05 : 11:=	07.10.50	TO " !!! C		<u> </u>	DEC "		
			•	DLUNTARY PAYMEN	-							
				ER NUMBER OF WE SENT "OTHER," PLE			ECTIVE D	ATE OF L	JSS _			
I ANT FIL							don: de!	one##=	on			
	iviakin	g a raise o		tatement for the p or civil prosecution					an res	suit iN		
		THIS IS TO	CERTIFY THAT	A COPY OF THIS FO	ORM HAS BE	EN MAILED C	R GIVEN T	O THE EM	IPLOY	EE		
39. Authorize	39. Authorized signature 40. Person Handling Clair					n (Please print) 41. Telephone Number 42. Dat				Date		

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

Jane Smith

EXAMPLE #2 - Filing Reason "A" Commencing benefits (with adjustments to base rate)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

02/12/2007

517-999-9999

PART A 1. Social Sec 111-22-3											
	curity Number	2. Date	e of Injury	3. Employee Name (Last	i, First, MI)	4. Dat	e of Birth	1	5. Dat	e of Death	
			1/2007	Doe, John R.	09/04/1950			0.24	o o. 2 od		
	Street Address th Elm Stre	et			7. City Lansing	8. Sta	te		9. ZIP 489		
10. Employe Smith's	r _{Name} Auto Repai	r			,		ederal ID 11111	Number 11	12. lnj	ury Location Code N/A	
	r Street Address outh Baker	Street			14. City Lansing	15. St MI	ate		16. ZI 489	P Code 15	
	r Self-Insured Na States Insur		pany		,		AIC or Se 99999	elf-Insured 99	Number		
19. Self-Insu	rer's Service Cor	npany Name				20. Se	ervice Co	mpany ID	Number		
21. ZIP Code 48912	e of Issuing Office		arrier or Self-Insure 345-1	d Claim Number	23. Date Carrier Received Noti 02/03/2007	ce of Injury			First Payme 7/2007	ent Made	
ART B											
25. Nature of Sprain (26. Part of Body Ankle (520)						
27. Average	Weekly Wage		28. Discontinu	ed Fringes	29. Second Employer A.W.W	'-	30. Se	cond Emp	loyer Discon	tinued Fringes	
\$ 450.00 \$ 0.00					\$			\$			
31. Tax Filing Status on Date of Injury C 32. Last Day Worked 02/01/2007					33. Number of Days in Work Week 7 34. Number of Dependents 3						
ART C											
35. Reason f	or Filing				36. Weekly Compensation B	ase Rate					
A					\$ 310.14						
37. Weekly A	Adjustments to Ba		\$		\$			\$			
	\$		\$		——— ↓ \$			\$			
38. Weekly A	mount Being Re	imbursed by a F	und (Not reported	on Line 37)							
	\$		\$_		\$		<u> </u>	\$			
ART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH		TO ⁻ AMOUN	TAL IT PAID	YEAR PAII	TERMINATION REASON	
Α	Α		\$0.00	02/02/2007							
			•		IT) OR LINE 37 IS EQUA						
					EKS AND EFF	ECTIVE D	ATE O	F LOSS			
- ANY FIL				ENT "OTHER," PLE							
	Makin	g a false or			urpose of obtaining or n, or both, and denial o			s can r	esult in		
		THIS IS TO (CERTIFY THAT	A COPY OF THIS FO	ORM HAS BEEN MAILED (OR GIVEN T	O THE	EMPLO	YEE		
39. Authorize	ed signature			40. Person Handling Claim	(Please print)	41. Telepho	ne Num	ber	42	2. Date	

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

Jane Smith

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT		\$ 450.00			
B. 80% AFTER-TAX AMOUNT OF (A)		\$ 310.14			
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT		\$ 387.68			
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION		100%			
G. INCOME TO BE COORDINATED ²		\$ 387.68			
the year of injury. ² Line G = (Line C + D + E) x Line F. (This figure SOCIAL SECURITY This section A. MONTHLY SOCIAL SECURITY OLD AGE	applies to old a	ge retirement benefits	· ·	efit with code "B" in Part C, L	ine 37)
B. WEEKLY SOCIAL SECURITY OLD AGE R	ETIREMENT AMOUNT	(Line A divided by 4.33)			
C. 50% OF LINE B					
D. 50% OF BASE RATE (Found in Box 36)					
E. IS DATE OF INJURY ON OR AFTER 12/19	/11?			☐ YES	□NO
IF NO – COORDINATE AMOUNT IN LINE					
IF YES – WERE SOCIAL SECURITY OLD	AGE RETIREMENT BE	NEFITS BEING PAID ON THE DA	ATE OF INJURY?	☐ YES	□NO
IF NO – COORDINATE AMOUNT IN L	INE C				
IF YES – COORDINATE THE LOWES	T AMOUNT FOUND IN	LINE C OR D			
				l	
UNEMPLOYMENT COMPENSAT	ION			<u> </u>	
A. NUMBER OF WEEKS AWARDED	COMPENSATION				
B. BEGINNING DATE OF UNEMPLOYMENT	COMPENSATION				
C. SCHEDULED EXPIRATION DATE D. TOTAL WEEKLY UNEMPLOYMENT COMI	DENICATION DENIETTO	. (Catana de "D" in Dont O. I.	: 07\		
PART F - RATE ADJUSTN (MCL 418.301(8) & 401(6)		OST INJURY WAG	E EARNING	CAPACITY (PIW	EC)
A. AVERAGE WEEKLY WAGE (On front, Line	27)				
B. 80% AFTER-TAX AMOUNT OF LINE A (Se	e calc program or rate of	charts)			
C. 100% AFTER-TAX AMOUNT (Line B multip	lied by 1.25)				
D. GROSS WEEKLY POST INJURY WAGE E	ARNING CAPACITY (P	WEC) AMOUNT			
E. DIFFERENCE BETWEEN 100% AFTER-T/ If the calculation in line E is less than or equ					
F. 80% of Line E (Line E multiplied by .8) ³					
G. AMOUNT OF ADJUSTMENT FOR PIWEC This figure should appear on front, Part C, L					
If the adjustment calculation shows an amo			applied.		

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals Authority: Completion: Workers' Disability Compensation Act, R408.31(6a-d) Mandatory
Workers' Disability Compensation Act, 418.631; 418.801 with disabilities. Penalty:

EXAMPLE #3 – Filing Reason "B" Change in weekly rate

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016. Lansing. MI 48909

FILING #	1
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42. Date

02/12/2007

41. Telephone Number

517-999-9999

				P.O. Box 30016	6, Lansing, MI 489	09				
PART A										
1. Social Sec 111-22-3	curity Number 3333		te of Injury 01/2007	3. Employee Name (Last, Doe, John R.	First, MI)		te of Birth 04/1950	5. Date of	of Death	
	Street Address			,	7. City Lansing	8. Sta	te	9. ZIP Co		
10. Employe	r Name				Larioning	11. Fe	ederal ID Number		/ Location Code	
	Auto Repa						1111111		N/A	
	r Street Address South Bake				14. City Lansing	15. St MI	ate	16. ZIP (48915		
	or Self-Insured Na States Insu	_{ame} rance Com	pany			-	AIC or Self-Insured	Number		
	ırer's Service Co		. ,			20. Se	ervice Company ID	Number		
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 2345-1	d Claim Number	23. Date Carrier Received 02/03/2007	Notice of Injury		e First Payment 7/2007	Made	
PART B		'								
25. Nature o					26. Part of Body Ankle (520)					
27. Average	Weekly Wage		28. Discontinu	ed Fringes	29. Second Employer A.	.W.W.	30. Second Em	oloyer Discontin	ued Fringes	
27. Average Weekly Wage \$ 450.00 \$ 0.00 31. Tax Filing Status on Date of Injury 32. Last Day Worked					\$ \$					
31. Tax Filin	g Status on Date	e of Injury	32. Last Day \ 02/01/20		33. Number of Days in Work Week 34. Number of D			Pependents		
PART C			1				•			
35. Reason f	for Filing				36. Weekly Compensation	on Base Rate				
A Weekly /	Adjustments to B	lase Rate			\$ 310.14					
or. Weekly r	•		\$		\$		9	3		
	\$		\$_		\$					
38. Weekly A			und (Not reported							
	\$		\$_		\$		\$	<u> </u>		
PART D		_	_							
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROU	UGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
Α	Α		\$ 310.14	02/02/2007						
IF BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQ	UAL TO "J" OF	R "K," ENTER	ORDER #		
IF BENEFI	T TYPE IS "(C" (SPECIFIC	C LOSS), ENT	ER NUMBER OF WE	EKS AND I	EFFECTIVE D	ATE OF LOSS	S		
IF ANY FIL	ING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLEA	ASE BE SPECIFIC					
	Makin	ng a false or			ırpose of obtaining , or both, and denia			esult in		
			J	p. 0000anon	, c. wour, and dome	5. 2011011101				

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

40. Person Handling Claim (Please print)

Jane Smith

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING # <u>2</u>	
-------------------	--

1. Social Sec 111-22-3	urity Number 3333		e of Injury 11/2007	3. Employee Name (I Doe, John R.	Last, First, M			e of Birth 04/1950	5. Date of	of Death	
	Street Address th Elm Stre	et			7. City Lans			te	9. ZIP Co 4891(
10. Employe Smith's	Name Auto Repa	ir			·		l l	ederal ID Number		Location Code	
	Street Address outh Bake				14. Cit Lans		15. St MI	ate	16. ZIP (Code	
	Self-Insured Na States Insu	ame rance Comp	oany		·		-	AIC or Self-Insured	l Number		
19. Self-Insu	rer's Service Co	mpany Name					20. Se	ervice Company ID	Number		
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1						te Carrier Received Notice 3/2007	e of Injury		e First Payment 7/2007	Made	
PART B		•			*			,			
25. Nature of Sprain (3						Part of Body kle (520)					
_	Weekly Wage		28. Discontinu		29. 9	Second Employer A.W.W.		30. Second Em	oloyer Discontin	ued Fringes	
\$ 450	.00 Status on Date	of Injury	\$ 0.00 32. Last Day V			Number of Days in Work V	Vook	\$ 34. Number of I)enendents		
C	- Clarad on Baro	or injury	02/01/200		7						
PART C	- Fill				1 00 1	Veekly Compensation Ba	- Data				
35. Reason f	or Filing						se Rate				
B 37. Weekly A	djustments to B	ase Rate				\$ 303.95					
,	•		\$			\$		Q	;		
	\$					\$			\$		
38. Weekly A	mount Being Re	eimbursed by a Fu	und (Not reported o	on Line 37)		\$		0			
	Ψ		Ψ_			Ψ		`	<u> </u>		
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATI REASON	
Α	Α		\$ 310.14	02/02/200	07	03/12/200	7 \$1,727.92		2007		
Α	Α		\$ 303.95	03/13/200	07						
- BASIS C	E DAYMEN	T IS OTHER	THAN "Δ" (\/Ω		ENT) OP	LINE 37 IS EQUAL	TO " I" OF	Y "K " FNTER	ORDER #		
2, 1010 C	· I /\ I IVILIN	. IO CITILIN		LOINITATION	_111) OI	LIIAL OF IO LOOKL	10 0 01	X IX, LINILIX	ONDEN #		

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THA	AT A COPY OF THIS FORM HAS BEEN MAILED C	R GIVEN TO THE EMPLOYEE	
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	0315/007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #4 - Filing Reason "C" Terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #1

PART A				F.O. BOX 3001	o, Lansii	ig, ivii 40303					
1. Social Security 111-22-333			e of Injury 1/2007	3. Employee Name (Las Doe, John R.	st, First, MI)		4. Date of Birth 09/04/1950			5. Date of	of Death
6. Employee Stree 123 North E		et			7. City Lansin	g	ite		9. ZIP C 48910		
10. Employer Nan Smith's Auto									Number 11	12. Injur	y Location Code N/A
13. Employer Stre 34310 Sout		Street			14. City Lansin	g	15. St	ate		16. ZIP (4891)	
17. Carrier or Self United State 19. Self-Insurer's	es Insura	ince Comp	oany				999	99999	elf-Insured 99 mpany ID		
21. ZIP Code of Is 48912	ssuing Office		rrier or Self-Insure 345-1	d Claim Number	23. Date 0	Carrier Received Notice o	l f Injury			First Payment 7/2007	Made
PART B 25. Nature of Injur	rv				26 Part	of Body					_
Sprain (310))					e (520)					
27. Average Week		28. Discontinu	· ·	29. Sec	30. Second Employer Discontinued Fring				ued Fringes		
\$ 450.00 \$ 0.00 31. Tax Filing Status on Date of Injury C				\$ \$ 33. Number of Days in Work Week 7 34. Number of Dependents 3							
PART C											
35. Reason for Fil	ling				36. Wee	ekly Compensation Base	Rate				
A					\$ 3	310.14					
37. Weekly Adjust		e Rate	\$			\$			\$		
\$								<u> </u>			
38. Weekly Amou	nt Being Reim	nbursed by a Fi	und (Not reported	on Line 37)							
\$_			\$_		<u> </u>				\$		
PART D											
	ENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOT AMOUN		YEAR PAID	TERMINATION REASON
Α	Α		\$ 310.14	02/02/2007	,						
IF BASIS OF P	PAYMENT	IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	NT) OR LII	NE 37 IS EQUAL T	O "J" OF	R "K," E	NTER (ORDER #_	
IF BENEFIT TY	YPE IS "C"	(SPECIFIC	LOSS), ENTI	ER NUMBER OF WE	EEKS	AND	EFFEC ⁻	TIVE D	ATE OF	LOSS	
IF ANY FILING	CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE BE S	PECIFIC					
	Making	a false or		tatement for the p					s can r	esult in	
	Т	HIS IS TO C	CERTIFY THAT	A COPY OF THIS FO	ORM HAS	BEEN MAILED OR	GIVEN T	O THE	EMPLC	YEE	

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

41. Telephone Number

517-999-9999

42. Date

02/12/2007

40. Person Handling Claim (Please print)

Jane Smith

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING#_	<u>2</u>
----------	----------

1. Social Sec 111-22-3	urity Number 3333		e of Injury 11/2007	3. Employee Name (Last, First, MI) Doe, John R.				4. Date of Birth 09/04/1950		of Death		
	Street Address h Elm Stree	et		1	7. City Lansing		8. State		9. ZIP Co 48910			
10. Employer Name Smith's Auto Repair							11. Federal II		12. Injury	Location Co		
	Street Address Outh Baker	Street			14. City Lansing		15. State MI		16. ZIP (4891			
	Self-Insured Nar		oany		•		18. NAIC or 9999999		Number			
9. Self-Insur	er's Service Com	pany Name					20. Service C	ompany ID	Number			
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1					23. Date Carrie 02/03/200	er Received Notice of 07	Injury		First Payment 7/2007	Made		
ART B												
25. Nature of Sprain (3					26. Part of B Ankle (5							
_	Weekly Wage		28. Discontinu	•		' '			30. Second Employer Discontinued Fringes			
\$ 450.00 \$ 0.00 31. Tax Filing Status on Date of Injury 32. Last Day Worked					\$ Number	of Days in Work Week	34 N	\$ 34. Number of Dependents				
C 31. Tax Filing Status on Date of Injury 32. Last Day Worked 04/04/2007					7	or bays in work weer	3	idilibel of b	ереписть			
ART C	or Filina				36. Weekly (Compensation Base R	ate					
С	Ü				\$ 310							
37. Weekly A	djustments to Ba				•							
	\$		\$_		<u> </u>			_				
	\$		\$_ und (Not reported			\$		\$				
38. Weekiy A	S	mbursed by a Fi		on Line 37)		\$		\$				
ART D												
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		OTAL INT PAID	YEAR PAID	TERMINA REASC		
А	А		\$ 310.14	02/02/200	7	04/06/2007	\$ 2,8	35.57	2007	А		
BASIS O	F PAYMENT	IS OTHER	THAN "A" (VC	LUNTARY PAYME	NT) OR LINE	37 IS EQUAL TO	"J" OR "K,"	ENTER (ORDER #_			
BENEFIT	TYPE IS "C	" (SPECIFIC	LOSS), ENT	ER NUMBER OF W	/EEKS	AND E	EFFECTIVE	DATE OI	LOSS			
						CIFIC			· ·			

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE					
39. Authorized signature		40. Person Handling Claim (Please print)	41. Telephone Number	42. Date	
		Jane Smith	517-999-9999	04/12/2007	

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #5 – Filing Reason "D" Commencing and terminating benefits

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

|--|

1. Social Sec 111-22-3	urity Number 3333		e of Injury)1/2007	3. Employee Name (La Doe, John R.	ast, First, MI)		4. Date of Birtl	Date of Birth 9/04/1950		of Death
	Street Address h Elm Stre				7. City Lansi	ng	8. State		9. ZIP Co	
10. Employe	· _{Name} Auto Repa	ir					11. Federal ID Number 38-1111111			/ Location Code
	Street Address outh Bake				14. City Lansi	ng	15. State MI		16. ZIP (48915	Code
	Self-Insured Natates Insu	_{ame} rance Com	pany				18. NAIC or S		lumber	
19. Self-Insu	rer's Service Co	mpany Name					20. Service Co	ompany ID N	lumber	
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1						Carrier Received Notice of 3/2007	I Injury	24. Date F	First Payment 2007	Made
PART B	1.2				L 00 D	w. (D.)				
25. Nature of Burn (12					Arm	rt of Body (310)				
•	27. Average Weekly Wage 28. Discontinued Fringes			cond Employer A.W.W.		30. Second Employer Discontinued Fringes				
\$ 450.00 \$ 0.00 31. Tax Filing Status on Date of Injury 32. Last Day Worked		33 Ni	\$ 33. Number of Days in Work Week		\$ 34. Number of Dependents					
C 02/01/2007			7							
PART C 35. Reason f	or Filina				36. W	eekly Compensation Base R	ate			
D	3					310.14				
37. Weekly A	djustments to E				<u> </u>					
	\$ \$			\$		\$_	\$			
\$ \$				\$ \$						
38. Weekly A		eimbursed by a F	und (Not reported o	on Line 37)		\$		\$		
PART D	*									_
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TAL NT PAID	YEAR PAID	TERMINATION REASON
Α	Α		\$ 310.14	02/02/200)7	03/12/2007	\$ 1,7	27.92	2007	А
F BASIS C	F PAYMEN	T IS OTHER	THAN "A" (VO	LUNTARY PAYME	ENT) OR L	INE 37 IS EQUAL TO) "J" OR "K," E	ENTER O	RDER #	
F BENEFI	TTYPE IS "	C" (SPECIFIC	C LOSS), ENTE	ER NUMBER OF V	VEEKS	AND I	EFFECTIVE [DATE OF	LOSS	
	ING CODES	ON THIS E	JDM DEDDES	ENT "OTHER " DI	EASE BE	SPECIFIC				

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

40. Person Handling Claim (Please print)

Jane Smith

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

41. Telephone Number

517-999-9999

42. Date

03/13/2007

EXAMPLE #6 - Filing Reason "F" Reopening claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING # 1

1. Social Section 111-22-3			e of Injury 01/2007	3. Employee Name (Last, First, MI) Doe, John R.				e of Birth 04/1950	5. Date o	f Death	
	Street Address h Elm Stre	et		I	7. City Lansing		8. State MI		9. ZIP Co 48910		
10. Employer Smith's A	Name Auto Repa	ir			1	11. Federal II 38-1111		444444		Location Code N/A	
	Street Address Outh Bake				14. City Lansing		15. State		16. ZIP 0 48915		
	Self-Insured Na tates Insur	ame rance Com	pany				-	AIC or Self-Insured	Number		
19. Self-Insur	er's Service Co	mpany Name					20. Se	rvice Company ID	Number		
21. ZIP Code of Issuing Office 48912 22. Carrier or Self-Insured Claim Number D12345-1				23. Date Carr 02/03/20	ier Received Notice of 07	<u>l</u> Injury		First Payment 7/2007	Made		
PART B		•			•			•			
25. Nature of Sprain (3	, ,				26. Part of I Ankle (
27. Average Weekly Wage 28. Discontinued Fringes			29. Second	Employer A.W.W.		30. Second Emp	loyer Discontinu	ued Fringes			
\$ 450.00 \$ 0.00			\$			\$					
31. Tax Filing Status on Date of Injury C 32. Last Day Worked 02/01/2007			33. Number	33. Number of Days in Work Week 7 34. Number of Dependents 3							
PART C											
35. Reason fo	or Filing				36. Weekly	Compensation Base R	ate				
D					\$ 31	0.14					
37. Weekly A	djustments to B		¢			¢.		¢.			
	5		—— ş_			\$ \$			\$ \$		
						\$		\$			
38. Weekly A	_	eimbursed by a F	fund (Not reported o	on Line 37)		\$		\$			
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
Α	А		\$ 310.14	02/02/2007	,	03/12/2007		\$ 1,727.92	2007	А	
F BASIS O	F PAYMEN ⁻	T IS OTHER	THAN "A" (\/O	LUNTARY PAYMEN	NT) OR I INF	37 IS FOLIAL TO) ".I" OR	"K" FNTFR	ORDER #		
D, 1010 0	/\IVILIN	· IO O II ILIN		LONIANT I ATME	11) OIL LINE	S. IO LOUAL IC		, LIVILIX	ONDEN #		

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC ___

THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED C	R GIVEN TO THE EMPLOYEE	
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	03/13/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #_	<u>2</u>
-----------	----------

PART A			P.O. Box 3001	o, Lansir	ig, ivii 46909					
1. Social Security Number 111-22-3333		e of Injury 01/2007	3. Employee Name (Last Doe, John R.	t, First, MI)			4. Date of Birth 09/04/1950		5. Date of	of Death
6. Employee Street Address 123 North Elm Stre	et		l	7. City Lansing	9	8. State			9. ZIP Co	
10. Employer Name Smith's Auto Repai	r			4	11. Federal ID No. 38-111111		4		/ Location Code N/A	
13. Employer Street Address 34310 South Baker	Street			14. City Lansing	9	15. State MI		16. ZIP (48915		
17. Carrier or Self-Insured Na United States Insur		pany					AIC or Self- 999999		Number	
19. Self-Insurer's Service Con	npany Name					20. Se	ervice Com	pany ID I	Number	
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1					arrier Received Notice o	I f Injury		24. Date 02/07	First Payment /2007	Made
PART B 25. Nature of Injury Sprain (310)				26. Part o						
27. Average Weekly Wage 28. Discontinued Fringes				29. Second Employer A.W.W. 30. Second Employer Discontinu				ued Fringes		
\$ 450.00		\$ 0.00		\$	\$		\$			
31. Tax Filing Status on Date C	1. Tax Filing Status on Date of Injury 32. Last Day Worked 04/04/2007		33. Numl	· ·		ber of De	f Dependents			
PART C		- 1		•						
35. Reason for Filing				36. Weel	dy Compensation Base	Rate				
F				\$ 3	10.14					
37. Weekly Adjustments to Ba	se Rate	\$			\$			\$		
\$		\$_			_			\$		
38. Weekly Amount Being Re	imbursed by a F	und (Not reported	on Line 37)							
\$		\$_			_ \$			\$_		
PART D										
BASIS OF BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOT <i>A</i> AMOUNT		YEAR PAID	TERMINATION REASON
A A		\$ 310.14	04/05/2007	,						
F BASIS OF PAYMENT	IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	NT) OR LIN	IE 37 IS EQUAL T	O "J" OR	R "K," EN	NTER C	RDER #_	
F BENEFIT TYPE IS "C	" (SPECIFIC	C LOSS), ENTI	ER NUMBER OF WE	EEKS	AND	EFFECT	TIVE DA	ATE OF	LOSS	
F ANY FILING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE BE S	PECIFIC					
Makin	g a false or		tatement for the portion				enefits	can re	esult in	
	THIS IS TO	CERTIFY THAT	A COPY OF THIS FO	ORM HAS I	BEEN MAILED OR	GIVEN T	O THE E	EMPLO'	YEE	

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

41. Telephone Number

517-999-9999

42. Date

04/12/2007

40. Person Handling Claim (Please print)

Jane Smith

EXAMPLE #7 – Filing Reason "G" Reopening and closing claim

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #1

PART A

1. Social Security Number 111-22-3333	2. Date of Injury 02/01/2007	3. Employee Name (Last, First, MI) Doe, John R.		4. Date of B 09/04/1		5. Date of Death
6. Employee Street Address 123 North Elm Street			7. City Lansing	8. State MI		9. ZIP Code 48910
10. Employer Name Smith's Auto Repair			1	11. Federal 38-1111		12. Injury Location Code N/A
13. Employer Street Address 34310 South Baker S	treet	14. City Lansing	15. State		16. ZIP Code 48915	
17. Carrier or Self-Insured Name United States Insuran	ce Company			18. NAIC or 999999	Self-Insured No 999	umber
19. Self-Insurer's Service Compa	ny Name			20. Service	Company ID No	umber
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Inst D12345-1	ured Claim Number	23. Date Carrier Received 02/03/2007	d Notice of Injury	24. Date F 02/07/2	irst Payment Made

IANID			
25. Nature of Injury		26. Part of Body	
Sprain (310)		Ankle (520)	
-1 ()		- (/	
27. Average Weekly Wage	28. Discontinued Fringes	29. Second Employer A.W.W.	30. Second Employer Discontinued Fringes
\$ 450.00	\$ 0.00	\$	\$
31. Tax Filing Status on Date of Injury	32. Last Day Worked	33. Number of Days in Work Week	34. Number of Dependents
C	02/01/2007	7	3

PART C

35. Reason for Filing		36. Weekly Compensation Base Rate	
D		\$ 310.14	
37. Weekly Adjustments to Base Rate			
\$	\$	\$	\$
\$	\$	\$	\$
38. Weekly Amount Being Reimbursed	by a Fund (Not reported on Line 37)		
\$	\$	\$	\$

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
Α	А		\$ 310.14	02/02/2007	03/12/2007	\$ 1,727.92	2007	Α

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS E	QUAL TO "J" OR "K," ENTER ORDER #	
IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS	AND EFFECTIVE DATE OF LOSS	
IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC		

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE						
39. Authorized signature 40. Person Handling Claim (Please print) 41. Telephone Number 42. Date						
	Jane Smith	517-999-9999	03/13/2007			

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #7 - continued

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #_	<u>2</u>
-----------	----------

1. Social Security Number 111-22-3333		e of Injury 01/2007	3. Employee Name (Las Doe, John R.			e of Birth 4/1950	of Death		
6. Employee Street Address 123 North Elm Stre	et		<u> </u>	7. City Lansing		8. State		9. ZIP C	
10. Employer Name Smith's Auto Repa	ir						deral ID Number	12. Injur	y Location Code
13. Employer Street Address 34310 South Bake				14. City Lansing		15. Sta	ate	16. ZIP (Code
17. Carrier or Self-Insured Na United States Insul		pany		.			IC or Self-Insure	d Number	
19. Self-Insurer's Service Co	mpany Name					20. Se	rvice Company I	O Number	
21. ZIP Code of Issuing Offic 48912		arrier or Self-Insure 345-1	d Claim Number	23. Date Ca 02/03/20	rier Received Notice of 007	Injury		te First Payment 7/2007	t Made
PART B 25. Nature of Injury				26. Part of	Rody				
Sprain (310)				Ankle					
27. Average Weekly Wage		28. Discontinue	ed Fringes		29. Second Employer A.W.W. 30. Second Employer Discontinued				ued Fringes
\$ 450.00 31. Tax Filing Status on Date	of Injury	\$ 0.00 32. Last Day V	Vorked	\$ 33. Numbe	\$ 33. Number of Days in Work Week 34. Number of Dependents				
C		04/04/200)7	7	3				
PART C 35. Reason for Filing				36 Week	/ Compensation Base R	ate			
G					0.14	aio			
37. Weekly Adjustments to B	ase Rate			ψ 3	0.14				
\$		\$_			\$			\$	
\$		\$_			\$			\$	
38. Weekly Amount Being Re	imbursed by a F		on Line 37)		\$			\$	
PART D									
BASIS OF BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATIO REASON
A A		\$ 310.14	04/05/2007	,	04/20/2007		\$ 708.89	2007	А
BASIS OF PAYMEN	l Γ IS OTHER	 THAN "A" (VO	LUNTARY PAYMEN	NT) OR LINE	37 IS EQUAL TO	"J" OR	"K," ENTER	ORDER #_	
BENEFIT TYPE IS "C	C" (SPECIFIC	LOSS), ENTE	ER NUMBER OF WE	EEKS	AND I	EFFECT	TIVE DATE C	F LOSS	
ANY FILING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE BE SP	ECIFIC				
			tatement for the p			! ! .			

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE						
39. Authorized signature	39. Authorized signature 40. Person Handling Claim (Please print) 41. Telephone Number 42. Date					
	Jane Smith	517-999-9999	04/22/2007			

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

EXAMPLE #8 - Filing Reason "H" Yearly report of partial payments

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

|--|

			o, Lansing, ivii 40909						
PART A 1. Social Security Number 2.	Date of Injury	3. Employee Name (Las	t, First, MI)	4. Dat	te of Birth		5. Date of	of Death	
111-22-3333	1/04/2007	Doe, John R.)4/195					
6. Employee Street Address 123 North Elm Street		,	7. City Lansing	8. Sta	te		9. ZIP C 48910		
10. Employer Name Smith's Auto Repair					ederal ID I 11111		12. Injur	y Location Code N/A	
13. Employer Street Address 34310 South Baker Street			14. City Lansing	15. St MI	ate		16. ZIP (4891		
17. Carrier or Self-Insured Name United States Insurance Co	mnany				AIC or Se 9999	If-Insured	Number		
19. Self-Insurer's Service Company Name						mpany ID	Number		
· ·	2. Carrier or Self-Insure	d Claim Number	23. Date Carrier Received Notice 11/08/2007	ce of Injury			First Payment	Made	
PART B			1		l.				
25. Nature of Injury Hearing Loss (230)			26. Part of Body Ears (124)						
27. Average Weekly Wage	28. Discontinu	•	29. Second Employer A.W.W			Second Employer Discontinued Fringes			
\$ 450.00 31. Tax Filing Status on Date of Injury	\$ 0.00 32. Last Day V		\$ Number of Days in Work \	Mook	\$ 34. Number of Dependents				
C	11/04/200		33. Number of Days in Work Week 7			3			
PART C									
35. Reason for Filing			36. Weekly Compensation Ba	ise Rate					
A			\$ 310.14						
37. Weekly Adjustments to Base Rate	c		¢			¢			
\$ \$		_	\$		_	— ф Ф			
38. Weekly Amount Being Reimbursed by			Ψ			Ψ			
\$\$		on Line 37)	\$			\$			
		-							
PART D		T							
BASIS OF BENEFIT SPECIAL PAYMENT TYPE PAYMENT		FROM	THROUGH		TOT AMOUN		YEAR PAID	TERMINATION REASON	
A B		11/05/2007	,						
IF BASIS OF PAYMENT IS OTHE	ER THAN "A" (VC	LUNTARY PAYMEN	NT) OR LINE 37 IS EQUAL	TO "J" OF	R "K," E	NTER C	ORDER #_		
IF BENEFIT TYPE IS "C" (SPECII	FIC LOSS), ENTI	ER NUMBER OF WE	EEKS AN	ND EFFEC	TIVE D	ATE OF	LOSS		
IF ANY FILING CODES ON THIS	FORM REPRES	ENT "OTHER," PLE	ASE BE SPECIFIC						
Making a false			urpose of obtaining or n, or both, and denial of			s can re	esult in		
THIS IS T	O CERTIFY THAT	A COPY OF THIS FO	ORM HAS BEEN MAILED C	R GIVEN T	O THE	EMPLO	YEE		

Jane Smith 517-999-9999 11/14/2007

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

41. Telephone Number

42. Date

40. Person Handling Claim (Please print)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

111-22-3333	ocial Security Number 2. Date of Injury 3. Employee Name (1-22-3333 11/04/2007 Doe, John R.			-	te of Birth 04/195		5. Date of Death
6. Employee Street Address 123 North Elm Stree	t		7. City Lansing	8. Sta	ate		9. ZIP Code 48910
^{10. Employer Name} Smith's Auto Repair				ederal ID 11111		12. Injury Location Code N/A	
13. Employer Street Address 34310 South Baker	Street		14. City Lansing	121 21111			16. ZIP Code 48915
17. Carrier or Self-Insured Nam United States Insura	·-				AIC or Se 199999	elf-Insured Nur 19	mber
19. Self-Insurer's Service Comp	pany Name			20. S	ervice Co	mpany ID Nur	mber
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1			23. Date Carrier Received 11/08/2007	23. Date Carrier Received Notice of Injury 24. Date First Payment 11/08/2007 11/11/2007			
PART B	•		•				
25. Nature of Injury Hearing Loss (230)			26. Part of Body Ears (124)				
27. Average Weekly Wage 28. Discontinued Fringes			29. Second Employer A.	29. Second Employer A.W.W.		30. Second Employer Discontinued Fringes	
\$ 450.00 \$ 0.00		00	\$	\$ \$			
\$ 450.00	31. Tax Filing Status on Date of Injury 32. Last Day Worked 11/04/2007		33. Number of Days in V	Vork Week	34. Nu	mber of Depe	ndents

35. Reason for Filing		36. Weekly Compensation Base Rate				
Н		\$ 310.14				
37. Weekly Adjustments to Base Rate		•				
\$	\$	\$	\$			
\$	\$	\$	\$			
38. Weekly Amount Being Reimbursed by a Fund (Not reported on Line 37)						
\$	\$	\$	<u> </u>			

PART D

BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
А	В			11/05/2007	12/30/2007	\$ 188.03	2007	
А	В			12/31/2007				

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #________
IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS ______ AND EFFECTIVE DATE OF LOSS ______
IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC ______

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THA	T A COPY OF THIS FORM HAS BEEN MAILED C	R GIVEN TO THE EMPLOYEE	
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date
	Jane Smith	517-999-9999	01/02/2008

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

Print Date: 08/01/2012 Print Time: 10:19:02

Workers' Compensation Agency Verification of Monetary Information Partial Benefit Rates

Page: 1 Version: 13.0

For Year: 2007

File Last

Name: John R. Doe **Update:** 08/01/2012 10:18:44

Prior to Injury

Year of Injury: 2007 **Gross Weekly Wage:** \$450.00 **Discontinued Fringes:** \$0.00 **Nbr of Dependents:** 3 3 Tax Class: **80 Percent Rate** \$310.14 (Including fringes)

After Injury

Begin	End	Year	80% Rate	Wages	80% Rate	Partial
Date	Date	Paid	Before Injury	Received	After Injury	Rate
11/05/2007	11/11/2007	2007	\$310.14	400.00	279.81	30.33
11/12/2007	11/18/2007	2007	\$310.14	386.00	271.25	38.89
11/19/2007	11/25/2007	2007	\$310.14	450.00	310.14	0.00
11/26/2007	12/02/2007	2007	\$310.14	410.00	285.92	24.22
12/03/2007	12/09/2007	2007	\$310.14	320.00	230.59	79.55
12/10/2007	12/16/2007	2007	\$310.14	425.00	295.10	15.04
12/17/2007	12/23/2007	2007	\$310.14	450.00	310.14	0.00
12/24/2007	12/30/2007	2007	\$310.14	450.00	310.14	0.00
Gra	and Totals:					\$188.03

Number of Weeks: 8

EXAMPLE #9 - Basis of Payment "B" Open Award

Benefits ordered @ \$3-+'\$&per week beginning on 3/12/06; accrued benefits paid on 5/8/07

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

1. Social Security Number 111-22-3333	2. Date of Injury 03/11/2006	3. Employee Name (L Doe, John R.	ast, First, MI)	st, First, MI) 4. Date of Birth 09/04/1950					f Death
6. Employee Street Address 123 North Elm Street	•		7. City Lansi	ng	8. Sta	ite		9. ZIP Co	
10. Employer Name Smith's Auto Repair						ederal ID Nu 1111111			Location Code
13. Employer Street Address 34310 South Baker Sti	reet		14. City Lansi		15. St MI	tate		16. ZIP C	ode
17. Carrier or Self-Insured Name United States Insurance	e Company					AIC or Self-I	nsured Numb	er	
19. Self-Insurer's Service Company	y Name				20. Se	ervice Comp	any ID Numb	er	
21. ZIP Code of Issuing Office 48912	22. Carrier or Self-Insu D12345-1	red Claim Number		Carrier Received Notice 8/2006	of Injury		4. Date First 05/08/200		Made
PART B 25. Nature of Injury			26 00	art of Body					
Heart Attack (991)			Hea	rt (801)					
27. Average Weekly Wage		nued Fringes		econd Employer A.W.W.			nd Employer [loyer Discontinued Fringes	
\$ 610.00 31. Tax Filing Status on Date of Inj	\$ 0.0 ury 32. Last Day			\$ 33. Number of Days in Work Week			\$ 34. Number of Dependents		
С	03/11/20	006	7			2	-		
PART C 35. Reason for Filing			1 26 W/	eekly Compensation Bas	o Pata				
A				397.02	e Rate				
37. Weekly Adjustments to Base R									
\$	\$			\$			\$		
\$				\$			\$		
38. Weekly Amount Being Reimbu	rsed by a Fund (Not reported) \$			\$			\$		
PART D									
	PECIAL TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT F		R PAID	TERMINATIO REASON
ВА	\$ 397.02	05/09/20	07	7					
F BASIS OF PAYMENT IS	•								
F BENEFIT TYPE IS "C" (S F ANY FILING CODES ON									
Making a	false or fraudulent	statement for the or civil prosecution		of obtaining or o	lenying b		can resul	t in	

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

41. Telephone Number

517-999-9999

42. Date

05/10/2007

40. Person Handling Claim (Please print)

Jane Smith

Print Date: 08/01/2012 Print Time: 11:36:49

Workers' Compensation Agency Verification of Monetary Information Accrued Payment & Interest

Version:	13.0

Begin Date	End Date	Paid Date	Comp Rate	Days Worked	Total Weeks	Rem Days	Total Comp	Total Interest	Total Comp & Interest
03/12/2006	05/08/2007	05/08/2007	\$397.02	7	60	3	\$23,991.35	\$1,347.69	\$25,339.04
•	Grand Totals					3	\$23,991,35	\$1.347.69	\$25,339,04

REPORT OF ACCRUED BENEFITS

SS#	111-22-3333	DOI	03/11/2006	Employee	Name	Doe, John R.
			_			
Order #	042007008	Basis	Payment Code	В	Year Paid	2007

Benefit Type	Special Payment	Adjusted Rate	From	Through	Total	Variable Rate Factors
А	А	\$397.02	03/12/2006	05/08/2007	\$23,991.35	Deps _ 2 _ Base Amt \$ _ 397.02 Adjustment Code \$ \$ Adjustment Code \$ \$
	В			05/08/2007	\$1,347.69	DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$
						DepsBase Amt \$ Adjustment Code \$ Adjustment Code \$

Basis of Payment

A = Voluntary Payment **General Disability** B = Open Award Partial Wage Loss C = Closed Award Specific Loss C = D = Stipulated Award Permanent Total D = E = Death

E = Compromise Form 115 Voluntary Pay Other F=

> Reduced Wage Earning Capacity W=

Weekly Adjustments to Base Rate

A = Wage Continuation Offset Advance Payment J = Social Security Coordination K = 30% Appeal Adjustment C = Pension Offset SIF Differential Benefits L = D = Unemployment Offset **Double Compensation** M= E = Disability Insurance Offset Third-Party Offset N = F = Self-Insurance Offset 2-Years Continuous Disability O = G = Other Benefit Coordination P = Recoupment of Overpayment Q Other

H = Age 65 Reduction Q =

I = Compensation Supplement Residual Wage Earning Capacity Reduction R =

Benefit Type

Special Payment

A = Accrued Benefits

B = Interest

C = 30% Appeal Adjustment

D = Other

EXAMPLE #10 – Basis of Payment "E" Compromise (rate and termination reason not required)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

|--|

1. Social Security I 111-22-333			of Injury 5/2007	3. Employee Name (La Doe, John R.	ast, First, MI)		5. Date	of Death		
6. Employee Stree 123 North E		l			7. City Lansi i	ng	8. State		9. ZIP C 4891	
10. Employer Nam Smith's Auto								deral ID Number	12. Injur	y Location Code N/A
13. Employer Stree 34310 South		treet			14. City Lansir	ng	15. Sta	ate	16. ZIP 4891	
17. Carrier or Self- United State		ce Comp	any					AIC or Self-Insure	d Number	
19. Self-Insurer's S	ervice Compa	ny Name					20. Se	rvice Company II) Number	
21. ZIP Code of Iss 48912	suing Office		rrier or Self-Insure 345-1	d Claim Number	23. Date 02/10	Carrier Received Notice (2007	of Injury		te First Payment 2/2007	: Made
PART B 25. Nature of Injury					26. Pai	t of Body				
Inflammation	,					440)				
27. Average Week	y Wage		28. Discontinu			cond Employer A.W.W.	' '			
\$ 0.00 31. Tax Filing Status on Date of Injury 32. Last Day Worked				33. Nui	33. Number of Days in Work Week 34			\$ 34. Number of Dependents		
PART C										
35. Reason for Fili	ng				36. We	ekly Compensation Base	Rate			
D					\$					
37. Weekly Adjustr					•					
\$_			\$_		_	\$;	§	
\$_			\$_		_	\$\$ \$;	§	
38. Weekly Amour	t Being Reimb	ursed by a Fu	ind (Not reported	on Line 37)		\$			§	
PART D										
		SPECIAL YAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH		TOTAL AMOUNT PAID	YEAR PAID	TERMINATIO REASON
E	А							\$ 1,500.00	2007	
F BASIS OF PA	YMENT IS	OTHER	THAN "A" (VC	LUNTARY PAYME	ENT) OR LI	NE 37 IS EQUAL T	O "J" OR	"K," ENTER	ORDER#_	0428070
						AND				
- ANY FILING	CODES OF	N THIS FO	KM KEPRES	SENT "OTHER," PL	EASE BE	SPECIFIC				
	N/1 - 1 - 1 - 1			tatement for the						

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

40. Person Handling Claim (Please print)

Jane Smith

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

41. Telephone Number

517-999-9999

42. Date

05/12/2007

EXAMPLE #11 – Basis of Payment "D" Permanent Total

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	2

1. Social Sec 111-22-3	urity Number 3333		e of Injury 5/2007	3. Employee Name (Las Doe, John R.	st, First, MI) 4. Date of Birth 09/04/1950			5. Date of	of Death		
	Street Address th Elm Stre	et		<u> </u>	7. City Lansing		8. State		9. ZIP Co		
10. Employe	Name Auto Repai	r					11. Federa	al ID Number 1111		/ Location Code	
	Street Address outh Baker	Street			14. City Lansing		15. State		16. ZIP 0 48915		
	Self-Insured Na States Insur		pany		1		18. NAIC 6	or Self-Insured 1999	Number		
19. Self-Insu	rer's Service Cor	npany Name					20. Servic	e Company ID	Number		
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 1345-1	d Claim Number	23. Date Car 10/18/20	rier Received Notice of 007	njury		e First Payment I/2007	Made	
ART B		•			•						
25. Nature of Industria	Injury II Loss of U	se			26. Part of Legs (5	,					
27. Average	Weekly Wage		28. Discontinu	ed Fringes	29. Second				oloyer Discontin	oyer Discontinued Fringes	
\$ 226			\$ 0.00		\$						
31. Tax Filino D	Status on Date	of Injury	32. Last Day V		33. Number of Days in Work Week 7		ek 34. Number of Dependents 2				
PART C 35. Reason f	- FW				L 00 W	O	-1-				
	or Filing					/ Compensation Base R	ate				
В					\$ 16	31.38					
37. Weekly A	djustments to Ba	ase Rate	\$			\$		\$	i		
	\$					\$		\$			
38. Weekly A	•	•	und (Not reported	on Line 37)							
	\$		\$_			\$		\$			
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUGH	AM	TOTAL OUNT PAID	YEAR PAID	TERMINATI REASON	
В	Α		\$ 161.38	10/16/2007	,	12/31/2007	\$	1,775.18	2007		
В	D		\$ 205.01	01/01/2008	,						

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _____

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #________
IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS _____ AND EFFECTIVE DATE OF LOSS ______

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE							
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date				
	Jane Smith		01/05/2008				

EXAMPLE #12 - Filing Reason "A" Rate with post injury wage earning capacity (PIWEC)

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1
----------	---

PART A				P.O. BOX 3001	o, Lai	ising, ivii 4690s	,				
	curity Number		e of Injury 5/2012	3. Employee Name (Last Doe, John R.	, First, N	ll)	4. Date of Bi 09/04/19				of Death
	Street Address th Elm Stre	et			7. City Lan:		8. Sta	8. State MI		9. ZIP C 4891	
	Auto Repa							11. Federal ID Number 38-111111		12. Injur	y Location Code N/A
	r Street Address South Bake				14. Cit Lan		15. S MI	15. State		16. ZIP 4891	
United S	or Self-Insured Na States Insur	rance Com	pany				-	IAIC or Se 99999	elf-Insured 99	Number	
19. Self-Insu	rer's Service Co	mpany Name					20. S	Service Co	mpany ID	Number	
21. ZIP Code 48912	e of Issuing Offic		arrier or Self-Insure 345-1	d Claim Number		te Carrier Received No. 5/2012	otice of Injury			First Payment 2/2012	Made
PART B 25. Nature o	floium				1 26	Part of Body					
Sprain (kle (520)					
27. Average Weekly Wage 28. Discontinue					· · ·				30. Second Employer Discontinued Fringes		
\$ 850.00 31. Tax Filing Status on Date of Injury 32			\$ 0.00 32. Last Day V		33.	\$ 33. Number of Days in Work Week		\$ 34. Number of Dependents			
С					7 3						
PART C 35. Reason	for Filing				36	Weekly Compensation	Base Rate				
Α						\$ 548.46					
_ *	Adjustments to B										
<u>R</u>	\$ 160.00	<u> </u>	\$_		\$\$						
	\$		\$_		\$			\$			
38. Weekly A	Amount Being Re	eimbursed by a F	und (Not reported o	on Line 37)	_	\$			\$		
PART D											
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM		THROUG	Ή		TAL NT PAID	YEAR PAID	TERMINATION REASON
Α	W		\$ 388.46	04/16/2012							
F BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	IT) OR	LINE 37 IS EQUA	AL TO "J" O	R "K," E	NTER (ORDER#_	
F BENEFI	T TYPE IS "C	C" (SPECIFIC	LOSS), ENTI	ER NUMBER OF WE	EKS_		AND EFFEC	TIVE D	ATE OF	LOSS	
F ANY FIL	ING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLE	ASE B	E SPECIFIC					
	Makin	g a false or		tatement for the participation					s can r	esult in	

THIS IS TO CERTIFY THA	THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE							
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date					
	Jane Smith	517-999-9999	02/12/2007					

PART E - COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED ²					
¹ Does not apply in all cases. If applicable, include the year of injury.	de the value of FICA and s	tate income tax using the figu	res provided in the back of	the agency's rate tables	corresponding to

² Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

SOCIAL SECURITY T	his section an	plies to old age	retirement benefi	ts only.	(Enter net benefit with code "B" in Part C, Lin	ne 37)
-------------------	----------------	-------------------------	--------------------------	----------	---	--------

A.	MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT		
В.	WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)		
C.	50% OF LINE B		
D.	50% OF BASE RATE (Found in Box 36)		
E.	IS DATE OF INJURY ON OR AFTER 12/19/11?	☐ YES	□NO
	IF NO – COORDINATE AMOUNT IN LINE C		
	IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	☐ YES	□NO
	IF NO – COORDINATE AMOUNT IN LINE C		
	IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D		

UNEMPLOYMENT COMPENSATION

A.	NUMBER OF WEEKS AWARDED	
В.	BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C.	SCHEDULED EXPIRATION DATE	
D.	TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A. AVERAGE WEEKLY WAGE (On front, Line 27)	\$ 850.00
B. 80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	\$ 548.46
C. 100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	\$ 685.58
D. GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	\$ 200.00
E. DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	\$ 485.58
F. 80% of Line E (Line E multiplied by .8) ³	\$ 388.46
G. AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	\$ 160.00

³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

EXAMPLE #13 – Filing Reason "A" Old-age social security benefits being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

42. Date

12/27/2011

41. Telephone Number

517-999-9999

DADT A				P.O. Box 30010	o, Lansing, MI 4890	09				
1. Social Sec 1111-22-3	curity Number		e of Injury 20/2011	3. Employee Name (Last Doe, John R.	, First, MI)		e of Birth)4/1949	5. Date of	of Death	
	Street Address th Elm Stre	et			7. City Lansing		te	9. ZIP C 48910		
10. Employe Smith's	r Name Auto Repa	ir				ederal ID Number	12. Injur	/ Location Code		
	r Street Address				14. City Lansing	15. St M I	ate	16. ZIP (Code	
	or Self-Insured Na States Insu	ame rance Com	pany				AIC or Self-Insured	l Number		
19. Self-Insu	ırer's Service Co	mpany Name				20. Se	ervice Company ID	Number		
21. ZIP Code of Issuing Office 22. Carrier or Self-Insured Claim Number D12345-1					23. Date Carrier Received 12/20/2011	Notice of Injury		e First Payment 7/2011	Made	
PART B										
25. Nature o Sprain (26. Part of Body Ankle (520)					
			28. Discontinu					30. Second Employer Discontinued Fringes		
·			\$ 0.00			Vork Week	\$ 34. Number of Dependents			
C					7 1 33. Number of Days in Work Week 34. Number of Dependence of Dependen			Dependents		
PART C	for Filing				36. Weekly Compensation	on Base Rate				
A	ioi i iiiig				\$ 416.89	Sir Base Nate				
	Adjustments to B									
<u>B</u>	\$ 208.45	<u> </u>	\$_		\$		9	<u> </u>		
	\$		\$_		\$			5		
38. Weekly A	•	eimbursed by a F	und (Not reported	on Line 37)	\$			S		
PART D										
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROU	JGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON	
Α	Α		\$ 208.44	12/21/2011						
IF BASIS C	OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQ	UAL TO "J" OF	R "K," ENTER	ORDER #_		
IF BENEFI	T TYPE IS "(C" (SPECIFIC	LOSS), ENT	ER NUMBER OF WE	EKS	AND EFFECT	IVE DATE OF	LOSS		
IF ANY FIL	ING CODES	ON THIS FO	ORM REPRES	ENT "OTHER," PLEA	ASE BE SPECIFIC					
	Makin	g a false or	fraudulent s	tatement for the p	urpose of obtaining	or denvina h	enefits can	result in		
	mann	g			, or both, and denia					

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

40. Person Handling Claim (Please print)

Jane Smith

PART E - COORDINATION OF BENEFITS

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER
A. WEEKLY BENEFIT AMOUNT					
B. 80% AFTER-TAX AMOUNT OF (A)					
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25
C. 100% AFTER-TAX AMOUNT					
D. FICA TAX ¹					
E. STATE INCOME TAX ¹					
F. % EMPLOYER CONTRIBUTION					
G. INCOME TO BE COORDINATED ²					

¹ Does not apply in all cases. If applicable, include the value of FICA and state income tax using the figures provided in the back of the agency's rate tables corresponding to the year of injury.

SOCIAL SECURITY This section applies to old age retirement benefits only. (Enter net benefit with code "B" in Part C. Line 37)

	COIAL SECONT 1 This section applies to old age retirement benefits only. (Enter her benefit	t with code B in Fait C, Line 37)
A.	MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT	\$ 2,100.00
В.	WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)	\$ 484.99
C.	50% OF LINE B	\$242.50
D.	50% OF BASE RATE (Found in Box 36)	\$ 208.45
E.	IS DATE OF INJURY ON OR AFTER 12/19/11?	☑ YES ☐ NO
	IF NO – COORDINATE AMOUNT IN LINE C	
	IF YES – WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?	⊠ YES □ NO
	IF NO – COORDINATE AMOUNT IN LINE C	
	IF YES – COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D	\$208.45

UNEMPLOYMENT COMPENSATION

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
2		

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory
with disabilities.	Penalty:	Workers' Disability Compensation Act, 418.631; 418.801

 $^{^{2}}$ Line G = (Line C + D + E) x Line F. (This figure should appear in Part C, Line 37, with the appropriate adjustment code)

³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

EXAMPLE #14 - Filing Reason "A" Old-age social security benefits not being paid on DOI occurring after 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

|--|

42. Date

12/27/2011

41. Telephone Number

517-999-9999

PART A				P.O. BOX 300 R	o, Lansing, Mi 4690s	y			
	curity Number		of Injury 0/2011	3. Employee Name (Last, Doe, John R.	First, MI)		e of Birth)4/1949	5. Date	of Death
6. Employee Street Address 123 North Elm Street		7. City Lansing	8. Star	te	9. ZIP C 4891				
10. Employer Name Smith's Auto Repair					ederal ID Number	12. Injur	y Location Code		
13. Employer Street Address 34310 South Baker Street				14. City Lansing	15. St	15. State MI		Code 5	
	or Self-Insured Na States Insu	ame rance Comp	oany				AIC or Self-Insure	d Number	
19. Self-Insu	urer's Service Co	mpany Name				20. Se	ervice Company II) Number	
21. ZIP Cod 48912	le of Issuing Offic		rrier or Self-Insure 345-1	d Claim Number	23. Date Carrier Received No. 12/20/2011	otice of Injury		e First Payment 7/2011	Made
PART B									
25. Nature of Sprain (26. Part of Body Ankle (520)				
_	Weekly Wage		28. Discontinu		29. Second Employer A.W	.W.	30. Second Em	ployer Discontin	ued Fringes
\$ 650		of lations	\$ 0.00		\$	nl. \\/ = nl.	\$	Dan an dan da	
C C	ng Status on Date	e of injury	32. Last Day \ 12/20/20		33. Number of Days in Wo	rk vveek	34. Number of 1	Dependents	
PART C 35. Reason	for Filing				36. Weekly Compensation	Base Rate			
A	g				\$ 416.89				
_ `	Adjustments to B				1				
<u>B</u>	\$ 242.50)	\$_		\$;	§	
	_ \$		\$_		\$;	§	
38. Weekly	Amount Being Re	eimbursed by a Fu	und (Not reported	on Line 37)					
	_ \$		\$_	_	\$			<u> </u>	
PART D				1					T
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THROUG	ЭН	TOTAL AMOUNT PAID	YEAR PAID	TERMINATION REASON
Α	Α		\$ 174.39	12/21/2011					
IF BASIS (OF PAYMEN	T IS OTHER	THAN "A" (VC	LUNTARY PAYMEN	T) OR LINE 37 IS EQU	AL TO "J" OF	R "K," ENTER	ORDER #_	
IF BENEFI	IT TYPE IS "(C" (SPECIFIC	LOSS), ENT	ER NUMBER OF WE	EKS	AND EFFECT	IVE DATE O	LOSS	
IF ANY FIL	ING CODES	ON THIS FO	RM REPRES	ENT "OTHER," PLEA	ASE BE SPECIFIC				
	Makin	ng a false or			rpose of obtaining o		enefits can	result in	
			criminal c	or civil prosecution	, or both, and denial	of benefits.			

NOTICE TO EMPLOYEE: IF ANY OF THE ABOVE INFORMATION IS INCORRECT, PLEASE CONTACT THE INDIVIDUAL NAMED IN LINE 40.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE

40. Person Handling Claim (Please print)

Jane Smith

	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER	
A. WEEKLY BENEFIT AMOUNT						
B. 80% AFTER-TAX AMOUNT OF (A)						
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25	
C. 100% AFTER-TAX AMOUNT						
D. FICA TAX ¹						
E. STATE INCOME TAX ¹						
F. % EMPLOYER CONTRIBUTION						
G. INCOME TO BE COORDINATED ²						
¹ Does not apply in all cases. If applicable, include the year of injury. ² Line G = (Line C + D + E) x Line F. (This figure			·	of the agency's rate tables co	orresponding to	
SOCIAL SECURITY This section	applies to old a	ge retirement benefits	only. (Enter net ben	efit with code "B" in Part C, Li	ne 37)	
A. MONTHLY SOCIAL SECURITY OLD AGE				\$ 2,100		
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)				\$ 484.99		
C. 50% OF LINE B				\$ 242.5	\$ 242.50	
D. 50% OF BASE RATE (Found in Box 36)				\$208.4	\$208.45	
E. IS DATE OF INJURY ON OR AFTER 12/19)/11?				□NO	

LINEMPI C	TIABMY	COMPENS	IAOITA:
OINLIVIE LC	/ I IVILIN I	COMPLINE	

IF NO - COORDINATE AMOUNT IN LINE C

IF YES - COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D

_		
	A. NUMBER OF WEEKS AWARDED	
	B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
Ī	C. SCHEDULED EXPIRATION DATE	
Ī	D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

☐ YES

Workers' Disability Compensation Act, 418.631; 418.801

⊠ NO

\$ 242.50

PART F - RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC)

IF YES - WERE SOCIAL SECURITY OLD AGE RETIREMENT BENEFITS BEING PAID ON THE DATE OF INJURY?

(MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)	
В.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)	
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)	
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT	
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.	
F.	80% of Line E (Line E multiplied by .8) ³	
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.	
³ F	or injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after	er-tax average weekly wage before the

LARA is an equal opportunity employer/program. Auxiliary aids, services and	Authority:	Workers' Disability Compensation Act, R408.31(6a-d)
other reasonable accommodations are available upon request to individuals	Completion:	Mandatory

Penalty:

personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 355.

with disabilities.

EXAMPLE #15 - Filing Reason "A"

Old-age social security benefits being paid or subsequently paid on DOI occurring before 12/19/11

NOTICE OF COMPENSATION PAYMENTS

Michigan Department of Licensing and Regulatory Affairs Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

FILING #	1

1. Social Sec 111-22-3			e of Injury)7/2011	3. Employee Name (Last Doe, John R.	t, First, MI)		ate of Birth 04/1949	5. Date of	of Death
	Street Address h Elm Stre	et		<u> </u>	7. City Lansing	8. St MI	ate	9. ZIP Co	
10. Employer Smith's A	_{Name} Auto Repai	r					ederal ID Number	12. Injury	/ Location Code
13. Employer 34310 Se	Street Address outh Baker	Street			14. City Lansing	15. S M I	State	16. ZIP (48915	
	Self-Insured Na tates Insur	ance Com	pany			-	18. NAIC or Self-Insured Number 999999999		
19. Self-Insur	er's Service Cor	npany Name				20. S	20. Service Company ID Number		
21. ZIP Code 48912	of Issuing Office		arrier or Self-Insure 2345-1	ed Claim Number	23. Date Carrier Receiv 12/20/2011	Received Notice of Injury 24. Date First Payment Made 12/27/2011			Made
PART B	Indiana.				OC Day (D.)				
25. Nature of Sprain (3					26. Part of Body Ankle (520)				
27. Average \	27. Average Weekly Wage 28. Discontinued Fringes			ed Fringes	29. Second Employer A.W.W. 30. Second Employer Discontinued Fringe			ued Fringes	
\$ 650.			\$ 0.00		\$				
31. Tax Filing C	Status on Date	of Injury	32. Last Day \\ 12/20/20		33. Number of Days in Work Week 7 34. Number of Dependents 1				
PART C 35. Reason fo	or Filing				36. Weekly Compens	ation Page Date			
A	or Filling				\$ 416.89	alion base Nate			
37. Weekly A	djustments to Ba				L				
<u>B</u>	\$ 242.50							i	
					\$		\$	<u> </u>	
-	mount Being Re	imbursed by a F	und (Not reported	on Line 37)	\$		\$	S	
PART D									
BASIS OF PAYMENT	BENEFIT TYPE	SPECIAL PAYMENT	TOTAL WEEKLY RATE	FROM	THE	ROUGH	TOTAL AMOUNT PAID	YEAR PAID	TERMINATIO REASON
Α	А		\$ 174.39	12/21/2011					
			İ						

IF BASIS OF PAYMENT IS OTHER THAN "A" (VOLUNTARY PAYMENT) OR LINE 37 IS EQUAL TO "J" OR "K," ENTER ORDER #______ IF BENEFIT TYPE IS "C" (SPECIFIC LOSS), ENTER NUMBER OF WEEKS ____ AND EFFECTIVE DATE OF LOSS IF ANY FILING CODES ON THIS FORM REPRESENT "OTHER," PLEASE BE SPECIFIC _______

> Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

THIS IS TO CERTIFY THAT A COPY OF THIS FORM HAS BEEN MAILED OR GIVEN TO THE EMPLOYEE					
39. Authorized signature	40. Person Handling Claim (Please print)	41. Telephone Number	42. Date		
	Jane Smith	517-999-9999	12/27/2011		

EXAMPLE #15 – contil						
PART E – COORDINATIO	N OF BENEF	ITS				
	PENSION	WAGE CONTINUATION	DISABILITY INSURANCE	SELF INSURANCE	OTHER	
A. WEEKLY BENEFIT AMOUNT						
B. 80% AFTER-TAX AMOUNT OF (A)						
	x 1.25	x 1.25	x 1.25	x 1.25	x 1.25	
C. 100% AFTER-TAX AMOUNT						
D. FICA TAX ¹						
E. STATE INCOME TAX ¹						
F. % EMPLOYER CONTRIBUTION						
G. INCOME TO BE COORDINATED ²						
¹ Does not apply in all cases. If applicable, include the year of injury.	de the value of FICA and	d state income tax using the figure	es provided in the back	of the agency's rate tables	corresponding to	
² Line G = (Line C + D + E) x Line F. (This figure	should appear in Part (C, Line 37, with the appropriate a	djustment code)			
SOCIAL SECURITY This section	applies to old a	ge retirement benefits	ONIV. (Enter net ben	efit with code "B" in Part C. I	Line 37)	
A. MONTHLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT				\$ 2,100.00		
B. WEEKLY SOCIAL SECURITY OLD AGE RETIREMENT AMOUNT (Line A divided by 4.33)				\$484.99		
C. 50% OF LINE B				\$242.	\$242.50	
D. 50% OF BASE RATE (Found in Box 36)				\$208	.45	
E. IS DATE OF INJURY ON OR AFTER 12/19/11?				☐ YES	⊠ NO	
IF NO – COORDINATE AMOUNT IN LINE	С			\$ 242	.50	
IF YES – WERE SOCIAL SECURITY OLD	AGE RETIREMENT BE	NEFITS BEING PAID ON THE D	ATE OF INJURY?	☐ YES	□NO	

UNEMPLOYMENT COMPENSATION

IF NO - COORDINATE AMOUNT IN LINE C

IF YES - COORDINATE THE LOWEST AMOUNT FOUND IN LINE C OR D

A. NUMBER OF WEEKS AWARDED	
B. BEGINNING DATE OF UNEMPLOYMENT COMPENSATION	
C. SCHEDULED EXPIRATION DATE	
D. TOTAL WEEKLY UNEMPLOYMENT COMPENSATION BENEFITS (Enter with code "D" in Part C, Line 37)	

PART F – RATE ADJUSTMENT³ FOR POST INJURY WAGE EARNING CAPACITY (PIWEC) (MCL 418.301(8) & 401(6))

A.	AVERAGE WEEKLY WAGE (On front, Line 27)				
B.	80% AFTER-TAX AMOUNT OF LINE A (See calc program or rate charts)				
C.	100% AFTER-TAX AMOUNT (Line B multiplied by 1.25)				
D.	GROSS WEEKLY POST INJURY WAGE EARNING CAPACITY (PIWEC) AMOUNT				
E.	DIFFERENCE BETWEEN 100% AFTER-TAX AMOUNT AND PIWEC (Line C minus Line D) If the calculation in line E is less than or equal to \$0, report base rate as adjustment amount in G.				
F.	80% of Line E (Line E multiplied by .8) ³				
G.	AMOUNT OF ADJUSTMENT FOR PIWEC (Base rate from front, Line 36, minus Line F) This figure should appear on front, Part C, Line 37, with appropriate adjustment code R. If the adjustment calculation shows an amount that is less than or equal to \$0, no adjustment can be applied.				
	³ For injury dates on or after 12/19/11, the weekly benefit rate payable is 80% of the difference between the injured employee's after-tax average weekly wage before the				

personal injury and the employee's wage earning capacity after the personal injury but not more than the maximum weekly rate determined under section 555.						
LARA is an equal opportunity employer/program. Auxiliary aids, se	ervices and Authority:	Workers' Disability Compensation Act.	R408.31(6a-d)			

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act, R408.31(6a-d)

Completion: Penalty: Workers' Disability Compensation Act, 418.631; 418.801